

SURGERY

UNDER THE CHARGE OF

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Thoracoscopy in Surgery of the Chest.—JACOBÆUS (*Surg., Gynec. and Obst.*, 1922, 34, 289) says that for diagnosis and localization of pleural and pulmonary tumors it is of great importance to make a roentgen-ray examination before as well as after the induction of pneumothorax. By making a roentgen-ray examination after the induction of pneumothorax, valuable information is obtained which completes the information already obtained by the roentgen-ray examination before the induction of pneumothorax. Thoracoscopic examination gives valuable information in diagnosing and localizing pleural and pulmonary tumors and verifies the roentgen-ray examination. If it is not possible to use a pressure difference apparatus, it might be advantageous to induce pneumothorax previous to operation in the pleural cavity. If a pressure difference apparatus be employed, then pneumothorax for the thoracoscopic examination ought to be induced as shortly before the operation as possible, in order that the inflation of the lung after the operation may not be rendered more difficult or impossible. If the lung is inflated after the operation, more favorable conditions for the course of healing are eventually obtained.

Gross Pathology of Brachial Plexus Injuries.—ADSON (*Surg., Gynec. and Obst.*, 1922, 34, 351) says that injuries of the brachial plexus are chiefly situated in the vicinity of the intervertebral canal proximal to the brachial trunk. The injuries may be slight, lacerating only the fascia around the cervical roots or they may be severe and result in laceration of the cervical roots between the cervical ganglion and the cervical trunk with or without avulsions of the ganglion. Inasmuch as injuries of the brachial plexus are produced in the root or the ganglion, they seem primarily to be lesions of the nerve rather than secondary to lesions of the shoulder joint. Patients with milder injuries may be expected partially or completely to recover without surgical treatment, but those with more severe injuries rarely recover even with surgical treatment.

Surgical Anatomy of the Trigeminal Nerve.—KANAVEL and DAVIS (*Surg., Gynec. and Obst.*, 1922, 34, 357) say that the distance from a point upon the inner surface of the squamous portion of the temporal bone opposite the pregenoid tubercle to the foramen spinosum was found to average 2.47 cm. There are six distinct types of middle meningeal arteries, the larger percentage of which give off single anterior and posterior branches. The distances from the foramen

spinosum to the Gasserian ganglion, foramen ovale and foramen rotundum respectively are 1.66 cm. at an angle of 20 degrees occipital from a transverse diameter through the foramen spinosum. In 41 per cent of the cases a marked bony prominence overhangs the foramen spinosum which leads to difficulty in elevating the dura mater and ligating the middle meningeal artery. Further, in 38 per cent marked lateral grooves are present which may lead to difficulty in localization of the operative field. An attempt should be made to save the motor root which lies medial to and somewhat superior to the sensory root centralward from the ganglion. A thin membrane lies between the Gasserian ganglion and the carotid artery in 40 per cent of the skulls examined. The cause of the paralysis of the seventh nerve which infrequently occurs cannot as yet be definitely stated.

Secondary Parotitis.—LYNN (*Surg., Gynec. and Obst.*, 1922, 34, 367) says that more attention should be paid to the condition of the mouths of our patients before and after operation. Following operations some mild salivary stimulant should be given to keep the ducts clean. The reason the sublingual and submaxillary glands are practically immune is because they are mucous glands, mucus inhibiting bacterial growth. Furthermore, the parotid is the only salivary gland containing lymph glands. These favor the collection of inflammatory agents. There are two main sources of infection: through the blood or lymph stream and by way of Stensen's duct.

A Study of Sixty-five Cases Seeking Relief After Short-circuiting Operations.—SPRIGGS and MARKER (*Brit. Med. Jour.*, April 15, 1922, p. 546) say that about half the patients who sought relief after gastro-enterostomy recovered from their symptoms or improved greatly with lapse of time and suitable medical treatment. In most of the remainder a detailed investigation showed abnormalities which are capable of relief by further operation. The conditions which call for a second operation are the persistent failure of medical treatment and inability of the patient to lead a normal life; particularly if it can be demonstrated that bile is regularly in the stomach or that the stoma is not in the lowest part, causing accumulation of food between the stoma and the pylorus, or that the jejunal loops are not normal in appearance, or that there is dilatation of the duodenum and regurgitation of bile, or if there is evidence of ulceration in the neighborhood of the stoma or of active ulceration of the stomach or duodenum. Except for structural disease, short-circuiting operations upon the colon should not be performed unless suitable and persistent medical treatment has failed and sound scientific reasons can be put forward for believing that the operation will benefit the patient. In all cases of chronic alimentary disease, treatment and especially operative treatment should not be undertaken until the case has been investigated as thoroughly as the circumstances permit.

Ascending Infections of the Kidney.—WALKER (*Lancet*, April 8, 1922, p. 684) says that organisms may also reach the kidney by the lymphatics surrounding the ureter and between its muscular coats, although the blood-stream is the commonest route. The kidney capsule is an